# Statement For the Record
# of the
# Hearing of the
# House Small Business Committee
# Subcommittee on Regulation, Health Care and Trade
# On
# "Medicare's Reimbursement Cuts: The Potential Impact on Solo and Small Group Practitioners and the Businesses They Run."

## Testimony of the American College of Physicians

## November 8, 2007

Thank you, Subcommittee Chairman Gonzalez and Ranking Member Westmoreland:

I am Jeffrey P. Harris, MD, FACP. I am the President-elect of the American College of Physicians, a general internist for three decades, and Clinical Associate Professor of Medicine at the University of Virginia School of Medicine. Until very recently, I practiced in a small, rural town in Virginia with a population of 50,000 people. The office which I practiced focused on the delivery of primary care and nephrology and routinely saw overhead expenses exceed 60 percent. As a community small business, we discovered first-hand the financial struggles that the reimbursement played on our practice.

The College is the largest medical specialty society in the United States, representing 124,000 internal medicine physicians and medical students. Of our members involved in direct patient care after training, approximately 20 percent are in solo practices and approximately 50 percent are in practices of 5 or fewer physicians. These practices are medicine's small businesses where much of their revenue is tied directly to Medicare's flawed reimbursement rates and formulas. The formula that controls the pool of available funding for the Medicare physician fee schedule, called the Sustainable Growth Rate (SGR), has lead to scheduled annual cuts for six consecutive years. On January 1, 2008, physicians face a 10.1 percent decrease in reimbursement unless Congress intervenes.

Many private insurance plans tie their fee schedule payments to those set under Medicare. Due to this significant influence, the College believes that we have an abiding professional commitment to making sure that our patients get the best care possible by advocating for payment policies that meet the needs of our elderly and disabled patients that are covered by Medicare and ensure access to care.

Instead of encouraging high quality and efficient care *centered on patients' needs*, however, existing Medicare payment policies have contributed to a *fragmented, high volume, over-specialized and inefficient model of health care delivery that fails to produce consistently good quality* outcomes for patients.

We greatly appreciate Subcommittee Chairman Charles Gonzalez and Ranking Member Lynn Westmoreland for focusing attention on the impact Medicare's flawed physician reimbursement formula impacts solo and small group practitioners. These are the practices that are the least able to absorb the uncertainty of annual payment decreases and the below inflationary adjustments Congress has grown accustomed to making.

**Medicare Payment Policies are Dysfunctional**
The College believes that Medicare payment policies are fundamentally dysfunctional because they do not serve the interests of Medicare patients or the taxpayers that support the program:

1. Medicare payment policies discourage internists and other primary and principal care physicians from organizing care processes to achieve optimal results for patients.

Research shows that health care that is *managed and coordinated by a patient's personal physician*, using systems of care centered on patients' needs, can achieve better outcomes for patients and potentially lower costs by reducing complications and avoidable hospitalizations. Such care usually will be managed and coordinated by a primary care physician, which for the Medicare population typically will be an internist who is trained in and practices in general internal medicine or geriatrics or a family physician.

Unfortunately, Medicare payment policies discourage primary and principal care physicians from organizing their practices to provide effective diagnosis, treatment and education of patients with chronic diseases:

- Medicare pays little or nothing for the work associated with coordination of care outside of a face-to-face office visit. Such work includes ongoing communications between physicians and patients, family caregivers, and other health professionals on following recommended treatment plans;

- Low fees for office visits and other evaluation and management (E/M) services discourage physicians from spending time with patients;

- Except for the one-time new patient Medicare physical examination and selected screening procedures, prevention is not covered at all;

- Low practice margins make it impossible for many physicians, especially in solo and small practices, to invest in health information technology and other practice innovations needed to coordinate care and engage in continuous quality improvement;

- Medicare's Part A and Part B payment "silos" make it impossible for physicians to share in system-wide cost savings from organizing their practices to reduce preventable complications and avoidable hospitalizations.

2. Medicare payment policies are contributing to an imminent collapse of primary care medicine in the United States.

As an educator at the University of Virginia School of Medicine, I've encountered hundreds of young people who are excited by the unique challenges and opportunities that come from being a patient's primary care physician. But when it comes to choosing a career path, very few see a future in primary care.

My medical students are acutely aware that Medicare and other payers undervalue primary care and overvalue specialty medicine. With a national average student debt of $150,000 and rising, by the time they graduate from medical school, medical students feel that they have no choice but to go into more specialized fields of practice that are better remunerated.

The numbers are startling:

- In 2004, only 20 percent of third year internal medicine residents planned to practice general internal medicine, down from 54 percent in 1998, and only 13 percent of first year internal medicine residents planned to go into primary care;

- The percentage of medical school seniors choosing general internal medicine has dropped from 12.2 percent in 1999 to 4.4 percent in 2004;

- A 2004 survey of board-certified internists found that after ten years of practice, 21 percent of general internists were no longer working in primary care compared to 5 percent for medical subspecialties working in their subspecialty.

This precipitous decline is occurring at the same time that an aging population with growing incidences of chronic diseases will need more primary care physicians to take care of them. Within 10 years, 150 million Americans will have one or more chronic diseases and the population aged 85 and over will increase 50 percent from 2000 to 2010.

3. The sustainable growth rate (SGR) formula has been wholly ineffective in restraining inappropriate volume growth, has led to unfair and sustained payment cuts, and has been particularly harmful to solo and small practices of primary care.

The SGR:

- Does not control volume or create incentives for physicians to manage care more effectively;

- Cuts payments to the most efficient and highest quality physicians by the same amount as those who provide the least efficient and lowest quality care;

- Penalizes physicians for volume increases that result from following evidence-based guidelines;

- Triggers across-the-board payment cuts that have resulted in Medicare payments falling far behind inflation;

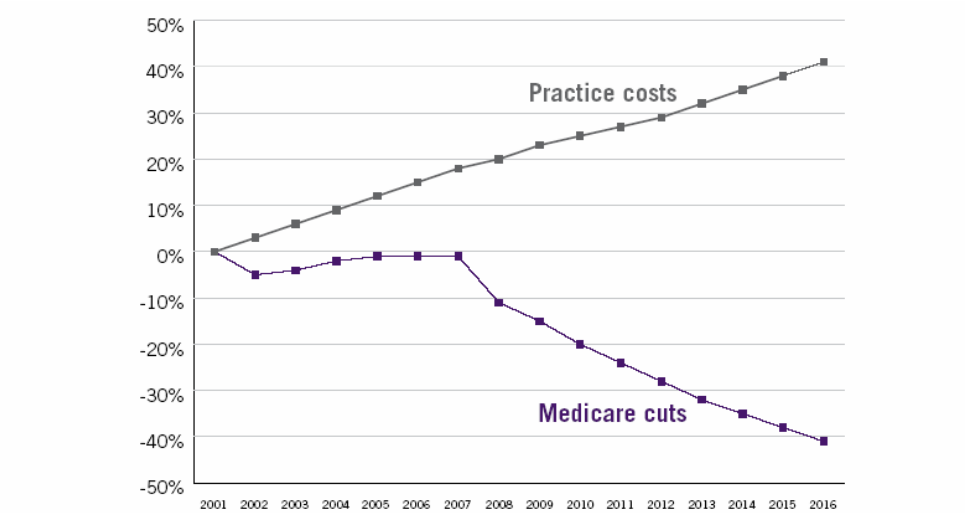
- Forces many physicians to limit the number of new Medicare patients that they can accept into their practices;

- Unfairly holds individual physicians responsible for factors—growth in per capita gross domestic product and overall trends in volume and intensity—that are outside of their control;

- Is particularly detrimental to primary care physicians in solo and small group practices, because they are already paid less than other specialties and have such low practice margins that they cannot absorb additional payment cuts.

The College recognizes and appreciates that with the support of this Subcommittee, the House passed legislation -- under the CHAMP Act -- to reverse the 10.1 percent SGR cut in Medicare payments scheduled to take place on January 1, 2008 and replace it with an annual 0.5 percent increase for 2008 and 2009. Unfortunately, the Medicare provisions were stripped out of the SCHIP reauthorization legislation as part of a compromise with the Senate.

Still, the legislation would not provide for an inflation update in 2008, which would make the seventh consecutive year that Medicare payments have declined relative to increases in the average costs physicians incur in providing services to Medicare patients. The chart below, courtesy of the American Medical Association, illustrates how Medicare payment has not kept up with actual practice costs and will continue to accelerate this trend unless Congress acts:




*Sources: Physician cost data is from the MEI, a conservative index of practice cost growth maintained by the Centers for Medicare & Medicaid Services. Medicare physician payment updates are from the 2007 Medicare Trustees report.*

**Creating a Framework for a Better Payment and Delivery System**
It is essential that Congress act this year to avert more SGR cuts, but we urge Congress not to simply enact another temporary fix without moving in a direction of replacing the underlying formula. *The so-called sustainable growth rate is simply not sustainable.* We strongly urge this Subcommittee to work with the authorizing committees in the House and the Senate to report legislation that puts Medicare on a pathway to completely eliminate the SGR.

1. Congress should set a specified timeframe for eliminating the SGR.

The College recognizes that the cost of eliminating the SGR will be very expensive, but the cost of keeping it—as measured by reduced access and quality—is much higher. Instead of enacting another temporary reprieve from the cuts without eliminating the SGR, the College believes that it would be preferable to set a "date certain" when the formula will be repealed, such as those Medicare provisions originally-contained in the CHAMP Act. Such a framework will allow for a transition period during which Congress and CMS could implement permanent payment reforms that can improve access and reduce costs, thereby reducing the perceived need for formula-driven volume controls like the SGR.

2. If there is a transition period before the SGR is repealed, Congress should mandate positive updates for all physicians in each year of the transition. The positive updates should reflect increases in the costs of providing services as measured by the Medicare Economic Index (MEI).

The College specifically recommends that any legislation that creates a pathway and timetable for repeal of the SGR should specify in statute the minimum annual percentage updates (floor) during the transition period. Establishing the minimum updates by statute will provide assurance to physicians and patients that payments will be fair and predictable during the transition.

3. Congress should authorize and direct Medicare to institute changes in payment policies to support patient-centered, physician-guided care management based on the patient-centered medical home model of care.

ACP, the American Academy of Family Physicians, and the American Osteopathic Physicians, have endorsed proposals for improving care of patients through a patient-centered practice model called the "personal medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006). Similarly the American Academy of Pediatrics has proposed a medical home for children and adolescents with special needs. The organizations, representing nearly 400,000 physicians, adopted a joint statement of principles that describes the key attributes of a patient-centered medical home:

***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

***Physician- directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care; chronic care; preventive services; end of life care.

***Care is coordinated and/or integrated*** across all domains of the health care system (hospitals, home health agencies, nursing homes, consultants and other components of the complex health care system), facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it.

***Quality and safety*** are hallmarks of the medical home:

- Evidence-based medicine and clinical decision-support tools guide decision making;
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement;
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met;
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication;
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.

***Enhanced access*** to care through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and office staff.

***Payment*** appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit associated with patient-centered care management;
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources;

- It should support adoption and use of health information technology for quality improvement;

- It should support provision of enhanced communication access, such as secure e-mail and telephone consultation;

- It should recognize the value of physician work associated with remote monitoring of clinical data using technology;

- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits);

- It should recognize case mix differences in the patient population being treated within the practice;

- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting;

- It should allow for additional payments for achieving measurable and continuous quality improvements.

Such payments could be organized around a "global fee" for care management services that encompass the key attributes of the patient-centered medical home.

4. Congress should direct Medicare to provide higher payments to physicians who acquire and use health information technology (HIT) to support quality measurement and improvement and authorize separate payments for e-mail and telephonic consultations that can reduce the need for face-to-face visits.

The College has endorsed H.R. 1952, the bipartisan "National Health Information Incentive Act" of 2007. We commend Subcommittee Chairman Gonzalez for introducing this important legislation to support the widespread adoption of HIT. Among other incentives for physician adoption of HIT, the legislation would direct Medicare to include an "add on" to office visit payments when such visits are supported by approved health information technology, conditioned on physician participation in designated programs to measure and report quality. The bill targets the "add on" to physicians in solo, small and rural practices, because the cost of acquiring HIT are insurmountable barriers for many of those practices.

Last week, the Administration embraced this new policy initiative by the announcement of a five-year demonstration project that will encourage small to medium-sized physician practices to adopt electronic health records (EHRs). Conducted by the Centers for Medicare & Medicaid Services (CMS), the demonstration would be open to participation

by up to 1,200 physician practices beginning in the spring. Over a five-year period, the program will provide financial incentives to physician groups using certified EHRs to meet certain clinical quality measures. A bonus will be provided each year based on a physician group's score on a standardized survey that assesses the specific EHR functions a group employs to support the delivery of care.

**Conclusion**

The College commends Subcommittee Chairman Gonzalez and the members of the House Subcommittee on Regulation, Health Care and Trade of the Small Business Committee for holding this important hearing to shine a spotlight on how the SGR is impacting solo and small physician practices.

We believe that it is critical that both the House and the Senate report legislation that will not only avert the pending 10.1 percent cut in Medicare physician reimbursement but also move toward enacting new Medicare payment policies that will improve quality and lower costs by aligning incentives with the needs of patients. This transition should:

- lead to repeal of the SGR by a specified date;
- guarantee at least two years of positive updates so that all physicians receive predictable and fair payments during any transition period;
- pay for the positive updates in a way that does not make the longer-term problem worse;
- allow time for Congress to review alternative approaches to addressing inappropriate volume increases during such a transition;
- increase reimbursement for care provided by primary and principal care physicians;
- implement an expanded pilot test of the patient-centered advanced medical home and other reimbursement changes to facilitate physician-guided care coordination;
- implement incentive-based payments for health information technology to support quality measurement and improvement;

I began my testimony by discussing why Medicare's payment policies are dysfunctional: because they are not aligned with patients' needs.

Congress has the choice of maintaining a deeply flawed reimbursement system that results in fragmented, high volume, over-specialized and inefficient care that fails to produce consistently good quality outcomes for patients. Or it can embrace the

opportunity to put Medicare on a pathway to a payment system that encourages and rewards high quality and efficient care *centered on patients' needs*.

The framework proposed by the College and outlined under the CHAMP Act will benefit patients by assuring that they have access to a primary or principal care physician who will accept responsibility for working with them to manage their medical conditions. Patients with chronic diseases will benefit from improved health and fewer complications that often result in avoidable admissions to the hospital. Patients will benefit from receiving care from physicians who are using advances in health information technology to improve care, who are fully committed to ongoing quality improvement and measurement, and who have organized their practices to achieve the best possible outcomes.

Medicare patients deserve the best possible medical care. They also deserve a physician payment system that will help physicians deliver the best care possible. The College looks forward to working with members of the Subcommittee and those on authorizing committees on legislation to reform physician payment that will help us achieve a vision of reform that is centered on patient's needs.

**HOUSE COMMITTEE ON SMALL BUSINESS**
**Witness Disclosure Statement**
**Required by House Rule XI, Clause 2(g)**

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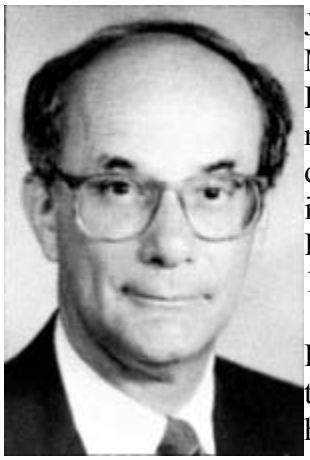
|---|---|---|
| **Your Name: Jeffrey P. Harris, MD, FACP** | | |
| **1. Are you testifying on behalf of a Federal, State, or Local Government entity?** | **YES** | **NO XXX** |
| **2. Are you testifying on behalf of an entity other than a Government entity?** | **YES XXX** | **NO** |
| **3. Other than yourself, please list what entity or entities you are representing:**<br><br>**American College of Physicians** | | |
| **4. Please list any offices or elected positions held or briefly describe your representational capacity with the entities disclosed in question 3.**<br><br>**President-elect, American College of Physicians** | | |
| ***(For those testifying on behalf of a Government entity, ignore these questions below)***<br><br>**5. a) Please list any Federal grants or contracts (including subgrants or subcontracts), including the amount and source (agency) which <u>you</u> have received and/or been approved for since October 1, 2006:**<br><br>**n/a**<br><br>**b) If you are testifying on behalf of a non-governmental entity, please list any federal grants or contracts (including subgrants or subcontracts) and the amount and source (agency) received by the <u>entities listed under question 3</u> since October 1, 2006, which exceeded 10% of the entities' revenues in the year received:**<br><br>**n/a** | | |
| **6. If you are testifying on behalf of a non-governmental entity, does it have a parent organization or an affiliate who you specifically do not represent? If so, list below:** | **YES** | **NO**<br><br>**XXX** |
| | | |

**Signature:** Jeffrey P. Harris **Date:** November 6, 2007

**President-elect - Jeffrey P. Harris, MD, FACP**



Jeffrey P. Harris, MD, FACP, Clinical Associate Professor of Medicine at the University of Virginia School of Medicine, is President-elect of the American College of Physicians (ACP), the national organization of internists. He became President-elect during Internal Medicine 2007 - ACP's annual scientific meeting in San Diego, April 19-21. He will become ACP President during Internal Medicine 2008, to be held in Washington, D.C., May 15-17.

Dr. Harris is a resident of Millwood, Va., where he has been in the practice of internal medicine and nephrology since 1977. He has served on the ACP Board of Regents, the organization's main policymaking body, since 2003. He also has served as Chair of the ACP Board of Governors for 2003-2004 and as the ACP Virginia Chapter Governor from 1999-2003.

As president-elect, Dr. Harris serves on the ACP Finance and Strategic Planning Committees. He was a member of the Board of Trustees of the ACP Foundation from 2004 to 2006. Dr. Harris served on the ACP Scientific Program Subcommittee from 1996 to 1998 and was the 2006-2007 Chair of the ACP Health and Public Policy Committee.

Dr. Harris was a member of the Board of Directors of Winchester Medical Center in Virginia from 1994 to 1998 and was President of the medical staff from 1990 to 1991. He also was Chairman of the Winchester Regional Advisory Board of the Thomas C. Sorensen Institute of Political Leadership, University of Virginia, from 1995 to 1998.

Dr. Harris earned his medical degree at The Medical College of Georgia in 1972. He completed his internship at the State University of New York, Downstate Medical Center. He completed residency training in internal medicine and fellowship training in nephrology at Georgetown University Hospital. He is certified in internal medicine and in nephrology. Dr. Harris has been a Fellow of the American College of Physicians (FACP) since 1981. FACP is an honorary designation that recognizes ongoing individual service and contributions to the practice of medicine.